Supreme Court, U.S.
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No. 92-547

In The

Supreme Court of the United States

October Term, 1992

FLORENCE B. CORCORAN, WIFE OF/AND
WAYNE D. CORCORAN,

Petitioners,

versus

UNITED HEALTHCARE, INC AND BLUE CROSS
AND BLUE SHIELD OF ALABAMA, INC.,

Respondents.

**Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Fifth Circuit**

BRIEF IN OPPOSITION TO THE PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

(1) Whether the Fifth Circuit Court of Appeals correctly decided that the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*, preempts state law claims, including claims for wrongful death and medical malpractice, against administrators of an ERISA plan who were acting in their capacity as plan administrators.

(2) Whether the Fifth Circuit Court of Appeals correctly decided that, assuming (a) Petitioner stated a claim under ERISA Section 502(a)(3)(B), 29 U.S.C. § 1132(a)(3)(B), and (b) this provision allowed recovery of extracontractual money damages as equitable relief, ERISA did not authorize emotional distress and mental anguish damages against a plan administrator.

LIST OF ALL PARTIES TO THE PROCEEDINGS BELOW

Florence B. Corcoran

Wayne D. Corcoran

United HealthCare, Inc.

Blue Cross and Blue Shield of Alabama, Inc.[1]

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[1] Pursuant to Sup.Ct.R. 29.1, Respondents inform the Court that United HealthCare, Inc. has no parent companies or nonwholly owned subsidiaries, and Blue Cross and Blue Shield of Alabama, Inc. has no parent companies or nonwholly owned subsidiaries.

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STATEMENT OF THE CASE

A. STATEMENT OF FACTS[2]

Petitioner, Florence B. Corcoran,[3] is an employee of South Central Bell Telephone Company entitled to certain medical and hospitalization benefits under the BellSouth Medical Assistance Plan (the "Plan"), a self-funded ERISA welfare benefit plan. BellSouth Corporation is the Plan Sponsor and Administrator. Various BellSouth subsidiaries, including South Central Bell, participate in the Plan. Pursuant to express Plan authority, BellSouth designated Blue Cross and Blue Shield of Alabama, Inc. ("Blue Cross") as the Claims Administrator, and United HealthCare, Inc. ("United") as the administrator of the Quality Care Program, a component of the Plan. As Plan Administrators, Blue Cross and United are ERISA fiduciaries.[4]

The linchpin of Petitioner's argument throughout these proceedings has been that the relationship between Petitioner and United is similar to the relationship between physician and patient, and that Petitioner's claims are based entirely on United's alleged medical negligence. This is untrue. Petitioner has admitted that the only relationship between Petitioner and United was the result of Petitioner's status as a Plan participant and

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[2] Because Respondents take issue with Petitioners' presentation of the facts of this case, Respondents set forth the "Statement of Facts" in order to preserve their right to contest Petitioners' version. *See* Sup.Ct.R. 15.1.

[3] Respondents will refer to Ms. Corcoran as "Petitioner." Respondents will not discuss Mr. Corcoran's claims separately, as they are entirely dependent upon the claims of Ms. Corcoran. Respondents expressly make any statement regarding Ms. Corcoran's claims equally applicable to those of Mr. Corcoran.

[4] As the Fifth Circuit noted, Petitioners challenge only findings regarding their claims against United. The Petition to this Court also refers only to United.

United's fulfillment of its responsibilities as the administrator of the Quality Care Program. (Appellees' Rec. Exc., p. 010, ¶ 31).[5] The District Court held as a matter of law that the Plan documents unambiguously refuted any claim that United acted as Petitioner's physician. Petitioners' Appendix ("Pet. App.") at A-50. The Fifth Circuit held United makes medical decisions only in the context of making benefits determinations under the Plan. 965 F.2d at 1331, Pet. App. at A-21.

United's responsibilities under the Plan are to determine what benefits will be paid for a participant's treatment, as set forth in an explanatory booklet concerning the Quality Care Program ("Explanatory Booklet") (Appellants' Rec. Exc., No. 5) and in the Summary Plan Description ("SPD") (Appellees' Rec. Exc., p. 028), which were both given to Petitioner. The Explanatory Booklet describes United's role as follows:

> Basically, QCP [Quality Care Program] works directly with your doctor. If your doctor recommends that you have surgery or go into the hospital for some kind of treatment, he or she simply telephones United HealthCare on a toll-free number and discusses your condition with a staff member. United will then advise your doctor what the medical plan will pay for, based on a review of your clinical information and nationally accepted medical guidelines for the treatment of your condition.

(Appellants' Rec. Exc., p. 16).

The Explanatory Booklet specifically tells the participant United is not her physician:

> In contrast, Quality Care is not:
>
> an attempt to limit your access to health care. You can always get any kind of treatment that

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[5] References are to the Record Excerpts filed with the Fifth Circuit Court of Appeals by Petitioners herein ("Appellants' Rec. Exc.") and by Respondents herein ("Appellees' Rec. Exc.").

> you wish. However, you may have to pay a portion of the cost.
>
> an attempt to interfere in the relationship between you and your doctor. You are free to consult any physician you wish.

(Appellants' Rec. Exc., p. 17).

The Explanatory Booklet explains that the consequence of not using United's services is that benefits under the Plan are reduced by 20% up to a maximum of $1,250. (Appellants' Rec. Exc., p. 20). Petitioner was specifically advised in the Explanatory Booklet that she is not required to use United's services and that she can "always get any kind of treatment that you wish", but that, "[h]owever, you may have to pay a portion of the cost."

To support the incorrect premise of this lawsuit, the existence of a physician-patient relationship between United and Petitioner, Petitioner cites portions of the booklet which state United is an independent professional medical review organization and discuss its professional staff. Pet. Brief at 3. These positive descriptions of United's professional nature are hardly sufficient to prove United was Petitioner's physician. Petitioner also points to some language discussing the unnecessary surgeries that occur in the United States. Pet. Brief at 3-4. This discussion, however, is in the context of explaining "runaway health care costs." (Appellants' Rec. Exc., p. 16-17). These statements are followed by the explicit provision that the program is not an attempt to limit Petitioner's access to health care or to interfere in the relationship between Petitioner and her doctor. (Appellants' Rec. Exc., p. 17).

The nature of the relationship between Petitioner and United is similarly explained in the SPD which was provided to Petitioner (Appellees' Rec. Exc., p. 003, ¶ 8):

> The Quality Care Program (QCP), administered by United HealthCare, Inc., assists you and vour covered dependents in securing quality medical

> care according to the provisions of the Plan while helping reduce risk and expense due to unnecessary hospitalization and surgery. They do this by providing you with information which will permit you (in consultation with your doctor) to evaluate alternatives to surgery and hospitalization when those alternatives are medically appropriate. In addition, QCP will monitor any certified hospital confinement to keep you informed as to whether or not the stay is covered by the Plan.
>
> * * *
>
> **When reading this booklet, remember that all decisions regarding your medical care are up to you and your doctor.**[6]

(Appellees' Rec. Exc., p. 029).

The SPD also explains that the consequences of not following the procedures with United are that Petitioner might have to pay 20% of the benefits from her own pocket, up to $1250. (Appellees' Rec. Exc., p. 029-30). If a claim for benefits is denied, the Plan sets forth appeal procedures (Appellees' Rec. Exc., p. 031).

Pursuant to the Quality Care Program procedures, when Ms. Corcoran was diagnosed during her pregnancy as having high blood pressure and preeclampsia, she and her doctor, Dr. Jason Collins, contacted United concerning her medical care and hospitalization benefits under the Plan. Petitioner admitted in the District Court that the purpose of Dr. Collins's call to United was to determine her Plan benefits. This was set forth in the Statement of Uncontested Material Facts as follows:

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[6] This statement is repeated in the SPD, at the end of the introductory explanation of the Quality Care Program, in bold print. (Appellees' Rec. Exc., p. 030).

> Pursuant to the Quality Care Program procedures set forth in the Summary Plan Description, when Ms. Corcoran became pregnant in 1989 and was diagnosed by her doctor, Dr. Jason Collins, as having high blood pressure and preeclampsia, United HealthCare was contacted by Dr. Collins and by Ms. Corcoran concerning her medical care and hospitalization benefits under the Plan. (Affidavit of Donna Armer).

(Appellees' Rec. Exc., p. 010, ¶ 30).

Petitioner also admitted in the District Court that her claims all relate to the ERISA plan:

> Plaintiffs' claims that United HealthCare and Blue Cross negligently deprived Ms. Corcoran of medical care, or hospitalization or otherwise engaged in negligent acts as administrators of the BellSouth Medical Assistance Plan all have a connection with or reference to the Plan and therefore relate to the Plan.

(Appellees' Rec. Exc., p. 010-11, ¶ 32).

In her Petition to this Court, Petitioner states, "the suit was not premised on improper claims processing or coverage determination, but rather upon United HealthCare's negligence in failing to determine the appropriate medical care for Mrs. Corcoran." Pet. Brief at 5-6. Regardless of how Petitioner characterizes her claim, the undisputed facts establish that her complaint is directed at United, a fiduciary and administrator of the Plan; complains about actions by United in its capacity as plan administrator; and complains about specific actions and judgments allegedly made by United about whether the Plan should authorize payment for Petitioner's hospitalization. As the Fifth Circuit correctly held, "The existence of a true doctor-patient relationship between Mrs. Corcoran and United . . . is dubious at best." 965 F.2d at 1337, Pet. App. at A-35. "United makes medical decisions as part and parcel of its mandate to decide what benefits are

available under the . . . plan." 965 F.2d at 1332, Pet. App. at A-24.

B. COURSE OF PROCEEDINGS AND DISPOSITION OF CASE BELOW

Petitioners filed suit on October 8, 1990, in the 22nd Judicial District Court for the Parish of St. Tammany, State of Louisiana, alleging United and Blue Cross negligently deprived Ms. Corcoran of medical care or hospitalization, and improperly provided inadequate medical oversight and incomplete medical information in connection with Petitioner's claim for benefits.

The Respondents removed the action to the United States District Court for the Eastern District of Louisiana on October 30, 1990, under 28 U.S.C. § 1331, because the claims arise under and are preempted by ERISA, and the district courts have jurisdiction over ERISA actions pursuant to Section 502(e)(1) of ERISA, 29 U.S.C. § 1132(e)(1).[7]

The District Court on March 8, 1991, granted Respondents' Motion for Summary Judgment. The District Court held ERISA preempted Petitioners' state law claims because the ERISA plan was the source of the relationship between the Corcorans and defendants, and thus the claims related to the plan:

> Here, the existence of the ERISA plan "is a critical factor in establishing liability under" the plaintiffs' would-be state-law malpractice claim. *Cf. Ingersoll-Rand*, 498 U.S. at ___, 111 S.Ct. at 483. . . .
>
> Without the ERISA plan, the plaintiffs could not establish – as an issue of fact – that the

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[7] Another basis for removal was complete diversity among Plaintiffs and Defendants, 28 U.S.C. § 1332.

> defendants breached any duty to them, for the source of the defendants' obligations arose from the ERISA plan itself . . . .

Pet. App. at A-44 to A-45.[8] The District Court on April 4, 1991 denied Petitioners' Motion for Reconsideration, declining to deviate from the majority rule that "a beneficiary under an ERISA health plan may not recover under section 509(a)(3) [sic] of ERISA compensatory or consequential damages for emotional distress or other claims beyond medical expenses covered by the plan." Pet. App. at A-49.[9] The District Court held this case did not implicate the concern over lack of a remedy because the plaintiffs did have a remedy when informed that hospital care would not be covered. The District Court also rejected Petitioners' position because under the language of § 502(a)(3), absent a violation of the terms of ERISA, there could be no claim for damages, and "plaintiffs can show no duty that the defendants allegedly breached under ERISA." The District Court held as a matter of law that the Plan documents unambiguously refuted any claim that United acted as Petitioner's physician. Pet. App. at A-50.

The Fifth Circuit affirmed the District Court's grant of summary judgment to Respondents. The Fifth Circuit held that the Corcorans' claims were preempted, because any actions by United were performed in its role as an ERISA plan administrator:

> Ultimately, we conclude that United makes medical decisions – indeed, United gives medical advice – but it does so in the context of

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[8] Respondents disagree with Petitioner's statement that the District Court reached a decision "[w]ithout actually analyzing the nature and source of the Corcorans' claim." Pet. Brief at 6.

[9] The relevant ERISA provisions are set forth in Petitioners' Appendix, at A-51 to A-53.

> making a determination about the availability of benefits under the plan.
>
> * * * *
>
> . . . The principle of *Pilot Life* that ERISA pre-empts state-law claims alleging improper handling of benefit claims is broad enough to cover the cause of action asserted here.

965 F.2d at 1331, 1332, Pet. App. at A-21, A-24.[10] The Fifth Circuit also explicitly held "the lack of an ERISA remedy does not affect a pre-emption analysis." 965 F.2d at 1333, Pet. App. at A-27.

With respect to the claim for extracontractual damages under § 502(a)(3), the Fifth Circuit expressly pretermitted the issues of whether Plaintiffs had stated a claim under the provision, and whether the provision permits the recovery of extracontractual damages within the meaning of "other equitable relief." Instead, the Fifth Circuit resolved the claim for damages by concluding that *even if* the Corcorans had stated a claim and *even if* such damages were within the statutory meaning of "equitable relief," the Petitioners would not be entitled to damages under the circumstances of this case, based on principles of trust and contract law. "The existence of a true doctor-patient relationship between Mrs. Corcoran and United which could support a contractual theory of recovery is dubious at best," 965 F.2d at 1337, Pet. App. at A-35, and "the lack of a true doctor-patient relationship between Mrs. Corcoran and United undermines . . . recovery" on the basis of a breach of a fiduciary relationship, 965 F.2d at 1338, Pet. App. at A-36.

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[10] Petitioner is incorrect that "the Fifth Circuit agreed with the Corcorans' position that United HealthCare made medical decisions . . . " Pet. Brief at 7. The Fifth Circuit stated expressly that it "cannot fully agree with either United or the Corcorans." 965 F.2d at 1331, Pet. App. at A-21.

SUMMARY OF THE ARGUMENT

Petitioner has failed to show any special or important reasons this Court should grant her Petition.

The holdings of the District Court and the Fifth Circuit Court of Appeals were correct as a matter of law. ERISA contains an explicit, broad preemption clause, under which Petitioner's claims were correctly held preempted, and a comprehensive civil enforcement scheme which was correctly held not to provide the type of remedies sought by Petitioners in this case.

Furthermore, Petitioner has failed to present any decisions of this Court or any other circuit court of appeals which conflict with the decision below regarding preemption; the one case presented is clearly distinguishable on its facts and law. With respect to damages, the Fifth Circuit correctly decided Petitioners were not entitled to emotional distress or mental anguish damages under ERISA. However, the Fifth Circuit expressly did not decide whether ERISA generally provides extracontractual remedies; thus, this is an issue not appropriate for review in this case. Although the Fifth Circuit expressly pretermitted the issues of whether ERISA generally provides extracontractual relief, or whether Petitioners had stated a cause of action for damages, authority in a majority of circuits provides an independent ground for affirming the result reached.

ARGUMENT

REASONS FOR DENYING THE PETITION

A. THE DECISION BELOW WAS CORRECT

The Court of Appeals' two holdings in the instant case are legally correct, and consistent with prior decisions

of this Court and those of other circuit courts. Thus, no review is needed or required.

The Court of Appeals held ERISA preempts the Petitioner's claims because even though the Court concluded United makes medical decisions, "it does so in the context of making a determination about the availability of benefits under the plan." 965 F.2d at 1331, Pet. App. at A-21. As the court correctly stated,

> Congress perhaps could not have predicted the interjection into the ERISA "system" of the medical utilization review process, but it enacted a pre-emption clause so broad and a statute so comprehensive that it would be incompatible with the language, structure and purpose of the statute to allow tort suits against entities so integrally connected with a plan.

965 F.2d at 1334, Pet. App. at A-27. The Court of Appeals properly applied the explicit and expansive ERISA preemption clause, in accord with Congressional intent and clear precedent.

Even assuming that the Corcorans state a claim for relief under § 502(a)(3)(B), and that extracontractual damages are an available remedy thereunder, the Fifth Circuit correctly decided that the facts of the instant case did not entitle the Corcorans to money damages under well-established trust and contract law principles because Petitioner seeks "make-whole" damages which cannot be available absent a "true doctor-patient relationship."[11]

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[11] The damages sought also should be unavailable because they do not constitute "other appropriate equitable relief." *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*, 793 F.2d 1456, 1463 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034, 107 S.Ct. 884 *and* 479 U.S. 1089, 107 S.Ct. 1298 (1987). Equitable relief consists of remedies such as rescission,

Further, the six carefully integrated civil enforcement provisions demonstrate that Congress did not intend to authorize any remedies under ERISA other than those expressly set forth in the statute. *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146, 105 S.Ct. 3085, 3092 (1985). This Court was "reluctant to tamper with an enforcement scheme crafted with such evident care as the one in ERISA." *Russell*, 473 U.S. at 147, 105 S.Ct. at 3093.

B. THE PETITION DOES NOT PRESENT ANY OF THE REQUISITE FACTORS CONSIDERED BY THIS COURT IN GRANTING A PETITION FOR WRIT

1. There is no conflict in the circuits over whether professional malpractice actions such as this one are preempted by 29 USC § 1144(a).

a. The allegedly conflicting case is distinguishable on its facts and law.

Appellants cite only one circuit court case, *Painters of Philadelphia Dist. Council No. 21 Welfare Fund v. Price Waterhouse*, 879 F.2d 1146 (3d Cir. 1989), which purportedly conflicts with the decision of the Fifth Circuit in this

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removal of a trustee or appointment of a receiver. *Id.* Like punitive damages, compensatory damages are not "equitable relief," but are legal in nature. *Chauffeurs, Teamsters and Helpers, Local No. 391 v. Terry*, 494 U.S. 558, 110 S.Ct. 1339, 1347-48 (1990). The Supreme Court noted in *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 105 S.Ct. 3085 (1985), that originally the civil enforcement provision provided for "the full range of *legal* and equitable remedies available in both state and federal courts." 473 U.S. at 146, 105 S.Ct. at 3092. In the bill ultimately adopted, however, the reference to legal remedies was omitted, indicating an affirmative choice by Congress to eliminate those remedies. *Id.*

case. *Painters* is distinguishable on its law and facts, and thus does not present a conflict.

In *Painters*, an employee welfare fund and its trustees sued the fund's former auditor under ERISA, alleging the auditors had a fiduciary duty to the plan to conduct audits in accordance with generally accepted accounting principles, and had breached this duty by failing adequately to investigate and evaluate fees and expenses charged by the plan administrator. The Third Circuit affirmed the district court's dismissal for failure to state an ERISA claim because (1) the auditor was not a fiduciary, and (2) ERISA provided no express or implied cause of action against a non-fiduciary under the circumstances of that case.

Factually, the case is completely dissimilar from the claim *sub judice*. In *Painters*, a plan and its trustees sued an entity it had retained to perform services. The relationship which formed the basis of the dispute was not one intended to be regulated by ERISA. The legal posture of the case differs because it was brought in Federal court by the fund under ERISA, and the issue was whether ERISA provided a cause of action.[12]

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[12] The district court cases cited by Petitioner to show a conflict among circuits are also distinguishable. *Pickett v. Cigna Healthplan of Texas, Inc.*, 742 F.Supp. 946 (S.D. Tex. 1990), was a suit against Cigna as operator of a health maintenance organization, acting independently from its capacity as plan administrator, in contrast to United, which was acting pursuant to its authority and responsibility under the Plan. *Independence HMO, Inc. v. Smith*, 733 F.Supp. 983 (E.D.Pa. 1990) was correctly held by the Fifth Circuit to be distinguishable on its facts because "the medical decisions at issue do not appear to have been made in connection with a cost containment feature of the plan or any other aspect of the plan which implicated the management of

b. The preemption discussion is dictum and thus does not constitute a conflicting decision

Preemption was not a determinative factor in *Painters;* the court did not need to address preemption at all to reach a decision on whether ERISA provided a cause of action. Thus, the Third Circuit's footnote discussion of preemption, 879 F.2d at 1153 n.7, is merely dictum, and Petitioner's presentation of this discussion as evidence of a conflict among circuits is incorrect.[13]

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plan assets, but were instead made by a doctor in the course of treatment." 965 F.2d at 1333 n. 16, Pet. App. at A-26 n.16.

[13] This is obscured by Petitioners' failure to distinguish between the preemption analysis in this footnote and the implied cause of action analysis in the body of the *Painters* opinion. Following their reference to the *Painters* preemption discussion, Petitioners write,

> The court premised *its conclusion* upon the facts that 1) professional malpractice liability was a matter of traditional state regulations, and 2) there was no explicit provision in ERISA to permit such actions under its provision *if state law were preempted.*

Pet. Brief at 12 (emphasis added). This suggests the *Painters* court premised its *preemption* conclusion on the listed factors, but the opinion does not support this. The court in its footnote does not discuss any relationship between preemption and whether or not professional liability is traditionally a matter of state law. Rather, the court's conclusion *that no cause of action should be implied,* following the *Cort v. Ash,* 422 U.S. 66, 95 S.Ct. 2080, 45 L.Ed.2d 26 (1975), four-factor analysis, was based, *inter alia,* on the fact that professional liability was traditionally a matter of state law. 879 F.2d at 1152-1153. Furthermore, the *Painters* court nowhere suggests that its *Cort* analysis depends on a preemption determination.

c. Even assuming the footnote preemption discussion constitutes a "decision," it is not a conflicting decision.

Even assuming, *arguendo*, that the footnote discussion of preemption is an adjudication of the matter, the Fifth Circuit's decision below and *Painters* are reconcilable and do not establish a conflict among circuits.

The court in *Painters* relied on this Court's decision in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 108 S.Ct. 2182 (1988) in concluding that professional malpractice actions *in general* were not preempted by ERISA. *Mackey*, and the cases it cited in dictum in the paragraph referenced by Petitioner, not only do not conflict with but in fact support the Fifth Circuit decision below.

The court in *Painters* concluded only that "ERISA does not generally preempt state professional malpractice claims." 879 F.2d at 1153 n.7. Such a holding does not conflict with the Fifth Circuit decision below, which held *specifically* that a state "tort action . . . for . . . wrongful death allegedly resulting from United's erroneous medical decision is preempted by ERISA." 965 F.2d at 1331, Pet. App. at A-21. As the Fifth Circuit explained, a "tort allegedly committed in the course of handling a benefit determination" is preempted under *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549 (1987). 965 F.2d at 1332, Pet. App. at A-24.

This Court in *Mackey* reconciled precisely that type of distinction between the general and the specific. In *Mackey*, the Supreme Court held a specific anti-garnishment statute directed to ERISA plans was preempted, while the generally applicable state garnishment statute was not. Analogously, the Fifth Circuit below held that a specific cause of action relating to an ERISA plan benefits

determination was preempted, while *Painters* held that professional liability law *generally* was not preempted.

A recent District Court decision squarely shows why *Painters* is distinguishable from and reconcilable with the decision below. In *Elsesser v. Hospital of Philadelphia College of Osteopathic Medicine, Parkview Div.*, 1992 U.S. Dist. LEXIS 16046 (E.D.Pa. 1992) (set forth in Appendix A), the District Court, relying on *Painters* and the Fifth Circuit decision below, held ERISA did not preempt a state law claim of medical malpractice, but did preempt state law claims of negligent failure to provide coverage, misrepresentation, and breach of contract. The plaintiffs sought to hold the defendant HMO vicariously liable for the allegedly negligent medical decisions of plaintiff's treating physician. The court held ERISA did not preempt these medical malpractice claims because "the allegations . . . do not rely on obligations under U.S. Health Care's benefits plan, but on the principles of professional malpractice," citing *Painters*. However, citing the Fifth Circuit decision below, the court held ERISA preempted all of plaintiff's remaining claims, including claims that the HMO negligently refused to pay for certain care, misrepresented the quality of care, and breached a contract to provide quality care, because all these claims clearly had "a connection with or reference to a benefit plan."

The distinction made by the *Elsesser* District Court between allegations of negligent medical treatment and allegations relating to the ERISA benefit plan establishes that the Fifth Circuit decision below was correct and not in conflict with *Painters*. In the instant case, Petitioner did not allege, and could not have alleged, an analogous "pure" medical malpractice claim against United, because United was not a physician who provided medical care to Petitioner. As the Fifth Circuit correctly concluded, "[t]he existence of a true doctor-patient relationship between Mrs. Corcoran and United . . . is dubious at best." 965

F.2d at 1337, Pet. App. at A-35. Because the only purportedly medical decisions at issue were made in connection with a benefit determination, any claim related thereto must be preempted, as the Fifth Circuit correctly held. Moreover, the *Elsesser* court properly interpreted the *Painters* preemption discussion as relating only to a true medical malpractice claim. The claim for failure to provide benefits, which is analogous to the instant case, was correctly held preempted; obviously the *Elsesser* court did not construe *Painters* as requiring a different result.

2. The Fifth Circuit Decision Does Not Conflict With Any Supreme Court Decision Construing 29 USC § 1144(a) Or The Legislative Purpose Embodied In ERISA.

a. The Fifth Circuit decision does not conflict with this Court's decision in *Mackey*.

Contrary to Petitioner's assertion, the Fifth Circuit decision below does not conflict with any Supreme Court decision. The case cited by Petitioner to support his claim of conflict, *Mackey*, has already been held *by this Court* to be distinguishable from and therefore consistent with the ERISA preemption Supreme Court decisions on which the Fifth Circuit relied.

In *Mackey*, this Court affirmed a Georgia Supreme Court decision that a state statute barring garnishment of ERISA welfare plan benefits was preempted, while the general state garnishment law was not preempted. This Court held the anti-garnishment statute's "express reference to ERISA plans suffices to bring it within the federal law's preemptive reach," 486 U.S. at 830, 108 S.Ct. at 2186. With respect to the general garnishment statute, however, this Court relied on ERISA provisions and the statute's structure to conclude Congress did not intend to

forbid state garnishment procedures against welfare plans. 486 U.S. at 831, 108 S.Ct. at 2186.

In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 111 S.Ct. 478 (1990), this Court held ERISA preempted a state common law claim of wrongful discharge to prevent attainment of ERISA pension benefits. The Court noted that although it had recognized certain limits to ERISA preemption, citing *Mackey* and *Ft. Halifax Packing Co. v. Coyne*[14], these limitations were not applicable in the case before it:

> We are not dealing here with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan. Nor is the cost of defending this lawsuit a mere administrative burden. Here, the existence of a pension plan is a critical factor in establishing liability under the State's wrongful discharge law. As a result, this cause of action relates not merely to pension benefits, but to the essence of the pension plan itself.

498 U.S. at ___, 111 S.Ct. at 483.

The limitation on preemption recognized in *Mackey* is not applicable in the case *sub judice* because, as the Fifth Circuit correctly held, "the central purpose of the lawsuit is to hold United liable for actions it took in connection with its duties under the plan." 965 F.2d at 1334, Pet. App. at A-29. As in *Ingersoll-Rand*, the court's inquiry in this case must be directed to the plan, because the action which forms the basis of the cause of action, "a tort allegedly committed in the course of handling a benefit

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[14] 482 U.S. 1, 23, 107 S.Ct. 2211, 2223-24 (1987) (holding that a state law which required payment of severance benefits was not preempted because the statute did not require the establishment or maintenance of an ongoing plan).

determination," 965 F.2d at 1332, Pet. App. at A-24, would not have occurred had there been no plan.

Petitioner cites the dicta in *Mackey* listing "run-of-the-mill" state law claims that the parties conceded were not preempted, including claims against plans for unpaid rent, for unpaid attorneys' fees, and for libel. 486 U.S. at 833 n.8, 108 S.Ct. at 2187 n.8. None of these state law cases is analogous here because they were totally unrelated to the performance by the defendant plan of any ERISA functions. Petitioner's characterization of the instant claim as within the "run of the mill tort claim" category is simply without any support in the *Mackey* decision. Nor would the Fifth Circuit agree with this characterization. The Fifth Circuit referenced the *Mackey* list of "run of the mill" state claims, 965 F.2d at 1329, Pet. App. at A-17, but nevertheless concluded the case was outside this category because it involved:

> . . . a tort allegedly committed in the course of handling a benefit determination . . . . The principle of *Pilot Life* that ERISA preempts state-law claims alleging improper handling of benefit claims is broad enough to cover the cause of action asserted here . . . . [T]he central purpose of the lawsuit is to hold United liable for actions it took in connection with its duties under the plan.

965 F.2d at 1332, 1334, Pet. App. at A-24, A-29.

A cause of action for medical negligence in connection with a benefit determination is neither a "run of the mill" state law claim, *Mackey*, 108 S.Ct. at 2187, nor a "generally applicable" cause of action that "functions irrespective of the existence of an ERISA plan." *Ingersoll-Rand*, 498 U.S. at ___, 111 S.Ct. at 483. Thus, the Fifth Circuit's conclusion that such a cause of action is preempted by ERISA does not conflict with *Mackey*.

b. The Fifth Circuit decision does not conflict with the legislative purpose of ERISA

Petitioner argues that preemption in this case is inconsistent with the purposes of ERISA because ERISA was adopted to protect "worker's [sic] rights," Pet. Brief at 18, and a state law which presumably also protects individuals by providing a remedy for "wrongful death due to medical negligence," Pet. Brief at 17, should not be preempted.[15]

Petitioner's argument is premised on the incorrect presumption that the purposes of ERISA and the state law governing medical negligence are the same. The legislative history of ERISA does not support this. As Petitioner correctly states, Congress enacted ERISA "to promote the interests of employees and their beneficiaries in employee benefits plan," Pet. Brief at 15. There is no support for an assertion that the state law of medical malpractice has the same purpose. It is an illogical leap to say that both "laws" have the same purpose because they both protect "worker's rights" [sic]. Carrying this argument to the extreme, under Petitioner's reasoning it would be inappropriate for any state law which gives remedies to individuals to be preempted by any Federal law with a similar effect.[16]

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[15] Although this argument goes to the merits of the Fifth Circuit decision and "conflict with legislative purpose" is not one of the enumerated reasons for a grant of certiorari under Sup.Ct.R. 10.1, Respondents address the argument to assure complete presentation of its position, and to point out errors in Petitioner's discussion of the law.

[16] Also flawed is Petitioner's conclusory statement that the remedy sought here is one "previously available under state law

Petitioner's argument also is premised on an incorrect representation of the opinion below. The Fifth Circuit specifically held that ERISA preempts the tort action because it was "allegedly committed in the course of handling a benefit determination," and because "the central purpose of the lawsuit is to hold United liable for actions it took in connection with its duties under the plan." 965 F.2d at 1332, 1334, Pet. App. at A-24, A-29. Petitioner's assertions that this claim is a "run of the mill tort claim for medical malpractice" and that Congress could not have "intended to deprive them of all remedies for wrongful death due to medical negligence" are misleading because they ignore this essential aspect of the Fifth Circuit decision.[17]

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prior to ERISA's enactment." Pet. Brief at 17. Although Louisiana law provides the remedy of money damages for wrongful death, *Danos v. St.Pierre*, 402 So.2d 633 (La.1981), it is incorrect that Louisiana necessarily provides a remedy for "medical malpractice committed in connection with a plan benefit determination," 965 F.2d at 1333, Pet. App. at A-26. Rather, this is a matter for which there is a "lack of clear Louisiana authority." 965 F.2d at 1328, Pet. App. at A-14.

[17] Furthermore, even assuming *arguendo* that the state and Federal laws at issue in this case have the same purpose, this Court has consistently rejected the argument that only state laws which conflict with federal laws should be preempted. *See Morales v. Trans World Airlines, Inc.*, ___ U.S. ___, 112 S.Ct. 2031, 2038 (1992) (relying on ERISA cases in rejecting the argument that preemption is inappropriate when state and federal law are substantively consistent, citing *Mackey*, 486 U.S. at 829, 108 S.Ct. at 2185, and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739, 105 S.Ct. 2380, 2388-2389 (1985)). Thus, even assuming there is a substantive link between a Federal law's purpose of protecting plan participants with respect to plan benefits, and a state law's purpose of providing a remedy for wrongful death, such an absence of conflict does not change the preemption analysis.

As an example of a case in which this Court held a state law not preempted because a preemption conclusion would conflict with Congressional intent, Petitioner cites *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 104 S.Ct. 615 (1984). This Court held in *Silkwood* that a punitive damages award for personal injuries suffered in a radiation accident was not preempted by the Federal law regulating safety of nuclear power plants. However, this Court in *Silkwood* expressly based its conclusion on explicit legislative history showing Congressional intent to allow state law tort remedies for personal injuries in connection with radiation accidents. 464 U.S. at 249-256, 104 S.Ct. at 622-626.

There is no analogous legislative history to support Petitioner's argument. As the Fifth Circuit noted, ERISA has an explicit, broad preemption clause with "deliberately expansive" language, "consistent with Congress's decision to create a comprehensive, uniform federal scheme for the regulation of employee benefit plans." 965 F.2d at 1328-1328, Pet. App. at A-15 to A-16.[18] To support the analogy to *Silkwood*, Petitioner would have to produce legislative history showing Congress intended to preserve state-law remedies for injuries resulting from failure of plans to comply with ERISA. Petitioner cannot

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[18] Because ERISA has an express broad preemption clause, Petitioner's citation of the reference in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380 (1985), to a presumption against preemption of areas of traditional state regulation is not persuasive. As the Fifth Circuit correctly held, "As cases such as *Ingersoll-Rand* . . . (other citations omitted) illustrate, the fact that states traditionally have regulated in a particular area has functioned as no impediment to *ERISA* pre-emption." 965 F.2d at 1334, Pet. App. at A-27 to A-28. (Emphasis added.)

make such an argument in the face of ERISA's comprehensive civil enforcement scheme.

That Petitioner seeks money damages unavailable under ERISA for "a tort allegedly committed in the course of handling a benefit determination," 965 F.2d 1332, Pet. App. at A-24, does not change the ERISA preemption analysis. As the Fifth Circuit correctly noted,

> The acknowledged absence of a remedy under ERISA's civil enforcement scheme for medical malpractice committed in connection with a plan benefit determination does not alter our conclusion. While we are not unmindful of the fact that our interpretation of the preemption clause leaves a gap in remedies within a statute intended to protect participants in employee benefit plans [citations omitted] . . . , *the lack of an ERISA remedy does not affect a pre-emption analysis.*

965 F.2d at 1333. Pet. App. at A-26 to A-27 (emphasis added).[19] *Cf. Caterpillar, Inc. v. Williams*, 482 U.S. 386, 391 n.4, 107 S.Ct. 2425, 2429 n.4 (1987) (rejecting Court of Appeals reasoning that case may not be removed to Federal court on preemption grounds unless Federal cause of action provides plaintiff with a remedy).[20]

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[19] As the District Court correctly noted, Petitioner had remedies available to her under ERISA for the denial of benefits, remedies that she did not exercise. She could have appealed the decision under the Plan appeal procedures, sued for a declaratory judgment regarding coverage on an expedited basis, or pursued the treatment recommended by her physician and sued under ERISA for coverage of her expenses. (Appellants' Rec. Exc. pp. 40-41).

[20] *See also Pohl v. National Ben. Consultants, Inc.*, 956 F.2d 126 (7th Cir. 1992), which held ERISA preempted a state law claim against a plan administrator seeking damages sustained as a

Congress intended in enacting ERISA that "plans and plan sponsors would be subject to a uniform body of benefit law" and not subject to the "burdens of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand*, 498 U.S. at ___, 111 S.Ct. at 484. The Fifth Circuit furthers this purpose by avoiding a decision that could lead "to the kind of patchwork scheme of regulation Congress sought to avoid." 965 F.2d at 1333, Pet. App. at A-25.

3. The Decision Of The Fifth Circuit Below Does Not Conflict With Decisions In Other Circuits Or Present An Unsettled Question Of Law Regarding Whether Extracontractual Damages Are Recoverable Under ERISA § 502(a)(3)(B), Because This Question Was Not Decided By The Fifth Circuit.

The Fifth Circuit in this case expressly pretermitted the issue of whether ERISA Section 502(a)(3)(B) permits the recovery of extracontractual damages, resolving the claim for damages instead by concluding that *even if* Petitioners had stated a claim under the provision, and *even if* such damages were an available remedy, the Petitioners would not be entitled to damages under the circumstances of this case:

> Assuming *without deciding*, therefore, that § 502(a)(3) permits the award of make-whole

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result of misrepresentation as to plan coverage:

> The fact that ERISA does not provide a substitute remedy reflects not a senseless gap in the statute but a determination to carry through the policy we have described by confining participants to the entitlements spelled out in writing. Not the semantics of the word "relate," but the policy of the statute, requires preemption and the denial of a remedy.

956 F.2d at 128.

> relief as 'other appropriate equitable relief,' we hold that the emotional distress and mental anguish damages sought here by the Corcorans are not recoverable.

(Emphasis added.) 965 F.2d at 1338, Pet. App. at A-36. Petitioner acknowledges that the Fifth Circuit did not decide this question. Pet. Brief at 19.

Whether or not there is a conflict in the circuits over this question thus is not relevant to the instant Petition. Even assuming that there is a conflict among circuits, and that the question is unsettled and of sufficient importance to warrant resolution by this Court, *this case* does not provide a basis for granting certiorari to resolve the question because the Fifth Circuit neither "rendered a decision" nor "decided an important question," Sup. Ct. R. 10, with respect to this ERISA provision. Thus, the issue would not be properly before this Court if certiorari were granted. Even if the issue is sufficiently important to justify resolution by this Court, it should be settled upon review of a case which decided this particular issue.

C. THE DECISION OF THE FIFTH CIRCUIT ALSO MAY BE AFFIRMED ON OTHER GROUNDS

Notwithstanding the Fifth Circuit's pretermission of this issue, the result reached was correct and may be affirmed on the following independent grounds.

1. ERISA Does Not Permit Recovery Of Extracontractual Or Compensatory Damages

Petitioner argues that if her state law claims are preempted by ERISA, she nonetheless has a cause of action under ERISA for compensatory extracontractual damages under 29 U.S.C. § 1132(a). Petitioner characterizes her claim as one arising under § 1132(a)(3). Petitioner's complaint, however, concerns actions which

United took in its capacity as a fiduciary of the Plan. Therefore, Petitioner's claims are more properly characterized as claims under § 1132(a)(2).[21]

The Supreme Court has held that extracontractual compensatory and punitive damages are not available under § 1109 and § 1132(a)(2). *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148, 105 S.Ct. 3085, 3093 (1985). Thus, Petitioner's claims for extracontractual damages are foreclosed. However, even if Petitioner's claims can be brought under § 1132(a)(3), virtually every court of appeals which has considered the issue has held that compensatory, punitive and other extracontractual damages are not available under § 1132(a) of ERISA.[22]

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[21] Section 1132(a)(2) allows a civil action to be brought for appropriate relief under the provision relating to breach of fiduciary duty, 29 U.S.C. § 1109.

[22] *See Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*, 793 F.2d 1456, 1463-1464 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034, 107 S.Ct. 884 *and* 479 U.S. 1089, 107 S.Ct. 1298 (1987); *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821, 825 (1st Cir. 1988), *cert. denied*, 488 U.S. 909, 109 S.Ct. 261 (1988); *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419, 424 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170, 106 S.Ct. 2892 (1986); *Reinking v. Philadelphia American Life Ins. Co.*, 910 F.2d 1210, 1219-20 (4th Cir. 1990); *Varhola v. Doe*, 820 F.2d 809, 817 (6th Cir. 1987); *Kleinhans v. Lisle Sav. Profit Sharing Trust*, 810 F.2d 618, 625-27 (7th Cir. 1987); *Hancock v. Montgomery Ward Long Term Disability Trust*, 787 F.2d 1302, 1306-07 (9th Cir. 1986); *Forys v. United Food & Commercial Worker's Int'l Union*, 829 F.2d 603, 604-05 n.2 (7th Cir. 1987); *Dependahl v. Falstaff Brewing Corp.*, 653 F.2d 1208, 1216 (8th Cir.), *cert. denied* 454 U.S. 968, 102 S.Ct. 512 *and* 454 U.S. 1084, 102 S.Ct. 641 (1981); *Sokol v. Bernstein*, 803 F.2d 532, 534-37 (9th Cir. 1986); *McRae v. Seafarer's Welfare Plan*, 920 F.2d 819, 821-23, *reh'g denied (en banc)*, 931 F.2d 901 (11th Cir. 1991); *c.f. Morales v. Pan American Life Ins. Co.*, 914 F.2d 83, 87 (5th Cir. 1990).

Petitioner's reliance on the case of *Warren v. Society Nat. Bank*, 905 F.2d 975, 982 (6th Cir. 1990), *cert. denied*, 111 S.Ct. 2256 (1991) is misplaced. Even in *Warren*, the Sixth Circuit held that, although compensatory damages may be appropriate in certain circumstances, extracontractual damages for *emotional distress* are excluded *per se* from "other appropriate equitable relief" under § 1132(a)(3). *Boland v. Chrysler Corp.*, 933 F.2d 1007 (table), 13 E.B.C. 2456, 2458 (6th Cir. 1991), *citing Warren*, 905 F.2d at 980, 983. *Warren* held that "clearly consequential damages" such as claims for emotional distress were not recoverable. *Id.* at 983.

Petitioner cites *Ingersoll-Rand*, as having "clearly suggested" that extracontractual money damages are recoverable under § 502(a)(3)(B). In *Ingersoll-Rand*, this Court held a state law claim for wrongful discharge to prevent attainment of ERISA pension benefits was preempted under ERISA's express preemption clause, and, alternatively, because the claim conflicted directly with Section 510 of ERISA, which makes it unlawful to discharge a plan participant for the purpose of interfering with the attainment of a right to benefits. In discussing this latter "conflict pre-emption," the Court stated that because § 502(a) provides the exclusive remedy for vindicating § 510-protected rights, an appropriate remedy must be available under § 502(a). 498 U.S. at ___, 111 S.Ct. at 486. To support an analogy to the instant case, Petitioners would have to point to a violation of an ERISA provision. Because they cannot do so, the analogy must fail.

The legislative history of ERISA also gives no support to a congressional intent to provide extracontractual damages of any kind. While Congress repeatedly emphasized the purpose of protecting contractually defined benefits, nowhere did the legislative history indicate an

intent to provide extracontractual damages. Indeed, Congress was concerned that the high costs of benefit plans would discourage employers from offering them. *Russell*, 473 U.S. at 148 & n.17, 105 S.Ct. at 3093 & n.17 (and legislative history cited therein). This concern about costs arises regardless of whether a participant seeks such damages under § 1109 or § 1132(a)(3).

Despite Petitioner's argument to the contrary, the same rationale for rejecting extracontractual damages under § 1109 applies in determining whether such damages are available under 29 U.S.C. § 1132(a)(3)(B). The logic of *Russell* "forecloses the availability of extra-contractual damages under § 502(a)(3) [§ 1132(a)(3)]." *Sokol v. Bernstein*, 803 F.2d 532, 536 (9th Cir. 1986). The legislative history of ERISA clearly indicates that "other appropriate equitable relief" means just that – injunctive or declaratory relief, such as removal of the trustee. *Id.* at 537 (and the legislative history cited therein). The *Sokol* court expressly rejected extracontractual claims for damages for emotional distress. *Id.* at 538.

In enacting the civil enforcement provisions of ERISA, Congress was balancing the interests of participants in protecting their accrued benefits and the need to encourage employers to provide benefit plans:

> Under the civil enforcement provision of § 502(a), a plan participant or beneficiary may sue to recover damages due under the plan, *to enforce the participant's rights under the plan, or to clarify rights to future benefits.* Relief may take the form of accrued benefits due, *a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits.*

Pilot Life, 481 U.S. at 53, 107 S.Ct. at 1556 (emphasis added). If the participant is forced to seek these remedies, the court has the discretion to award attorneys fees under

29 U.S.C. § 1132(g). *Id.* Thus, Petitioner's rights as a participant were fully protected by ERISA.

Any concern about the breadth of ERISA preemption and the narrowness of the civil enforcement provisions must be addressed to Congress, not this court. *See Russell*, 473 U.S. at 145; 105 S.Ct. at 3092.

2. Even If Compensatory Or Other Extra-contractual Damages Were Available Under ERISA, Plaintiff Has No Claim Under ERISA, Because Defendants Did Not Breach Any ERISA Fiduciary Duties To Plaintiff

Even if compensatory or other extracontractual damages were available, Petitioner had no claim under ERISA because Respondents breached no ERISA fiduciary duties. The facts alleged in Petitioner's complaint all concern an alleged physician-patient relationship between United and Petitioner or assume that United had a duty to Plaintiff to make recommendations regarding her treatment.

The District Court, upon reviewing the plan documents, determined that the only relationship between the parties was that of plan administrator and participant, as made clear by the SPD and Explanatory Booklet:

> [T]he ERISA plan here concerned only the payment, not the medical propriety, of health-care expenses and expressly provided that no such doctor-patient relationship was created by the plan: the plan contained specific warnings that all health care decisions were for the plan participant and her treating doctor to make.

(Appellants' Rec. Exc. p. 41). Respondents had no duty under ERISA to determine what type of treatment was appropriate for Petitioner. Rather, Respondents made coverage determinations.

The Fifth Circuit also concluded correctly, "The existence of a true doctor-patient relationship between Mrs. Corcoran and United which could support a contractual theory of recovery is dubious at best." 965 F.2d at 1337, Pet. App. at A-35, and "the lack of a true doctor-patient relationship between Mrs. Corcoran and United undermines . . . recovery" on the basis of a breach of a fiduciary relationship, 965 F.2d at 1338, Pet. App. at A-36.

Petitioner has not argued that Respondents wrongfully failed to perform their duties under the Plan.[23] Therefore, Petitioner has no claim under ERISA.

CONCLUSION

It is respectfully submitted that petitioner has wholly failed to sustain its burden of establishing under Sup.Ct.R.10 that there are special and important reasons the writ should be granted. The decision below does not conflict with applicable decisions of this Court or of another Court of Appeals on the same matters; nor has the Court of Appeals decided an important federal question which has not been, but should be, settled by this court at this time. The Fifth Circuit Court of Appeals correctly decided that Petitioner's claims are preempted, and that Petitioner is not entitled to extracontractual

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[23] Petitioner admits she has been paid all benefits due and owing to her under the Plan relating to the pregnancy. (*See* Appellees' Rec. Exc., pp. 37-38.)

damages under the circumstances of this case. Therefore, the Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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APPENDIX A

VIRGINIA ELSESSER and COURAGE VERZICCO, co-guardians of the Estate and Person of CAROLYN VERZICCO, an incompetent

VS.

HOSPITAL OF THE PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE, PARKVIEW DIVISION, a Pennsylvania Corporation, et al

C.A. NO. 92-3045

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

1992 U.S. Dist. LEXIS 16046

September 30, 1992, Decided
September 30, 1992, Filed

COUNSEL: [*1]

For VIRGINIA ELSESSER, COURAGE VERZICCO, Co-Guardians of the Estate and Person of Carolyn Verzicco, an incompetent, PLAINTIFFS: GARY M. GUSOFF, 2401 WALNUT ST., SUITE 102, PHILA., PA 19103.

For U.S. HEALTHCARE, INC., DEFENDANT: GILBERT F. CASELLAS, KIMBERLY H. HUMES, MONTGOMERY, MC CRACKEN, WALKER & RHOADS, THREE PARKWAY, 20TH FL., PHILA, PA 19102, USA.

JUDGES: WEINER

OPINIONBY [sic]: CHARLES R. WEINER

OPINION: MEMORANDUM OPINION AND ORDER

WEINER, J.

SEPTEMBER 30, 1992

Plaintiffs originally brought this personal injury action in the Court of Common Pleas of Philadelphia

County against a hospital, several doctors in the emergency room of the hospital, plaintiffs' incompetent's primary care physician, and United States Health Care Systems of Pennsylvania, Inc. ("U.S. Health Care"), a health maintenance organization ("HMO"). U.S. Health Care subsequently removed the action to this court pursuant to 28 U.S.C. @ 1441(b), claiming that the causes of action plaintiffs assert against it arise under the laws of the United States. The suit arises out of personal injuries allegedly sustained by plaintiffs' incompetent Carolyn Verzicco ("Verzicco") as a result of care she received at the hospital [*2] of the Philadelphia college of Osteopathic Medicine, Parkview Division ("Parkview") in connection with U.S. Health Care's selection of primary care physicians. U.S. Health Care filed a motion to dismiss the Complaint against it for failure to state a claim upon which relief can be granted pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure. In its motion, U.S. Health Care argued that plaintiffs' state law claims asserted against it should be dismissed as pre-empted by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. @ 1001 et seq. Plaintiffs responded by filing a motion to remand the entire action to the state court on the basis that the state claims are not preempted by ERISA. By Memorandum Opinion and Order dated July 13, 1992, we denied the motion to dismiss and granted the motion to remand. Presently before the court is the motion of U.S. Health Care for reconsideration n1 or, in the alternative, for certification for immediate appeal under 28 U.S.C. Section 1292(B). For the reasons which follow, the motion for reconsideration is granted in part and denied in part and the motion for certification [*3] is denied.

----------Footnotes----------

n1 Plaintiffs argue that 28 U.S.C. @ 1447(d) precludes a district court from reconsidering an Order

remanding a case to the state court. Section 1447(d) states that, except for civil rights cases removed pursuant to 28 U.S.C. @ 1443, "an order remanding a case to the State Court from which it was removed is not reviewable on appeal or otherwise . . . " We read this language to preclude only certain appellate review of a remand order. Indeed, we have located four decisions wherein a district court entertained a motion for reconsideration of an Order remanding a case to state court. See e.g. State of Fla. v. Simanonok, 850 F.2d 1429 (11th Cir. 1988); Smith v. Anadrill, Inc., 762 F.Supp. 1267 (S.D. Tex. 1991); Knickerbocker v. Chrysler Corp., 728 F.Supp. 460 (E.D. Mich. 1990); Litka v. University Of Detroit Dental School, 610 F.Supp. 80 (D.C. Mich. 1985).

---------- End Footnotes ----------

Accepting the allegations in the complaint as true as we must when considering a Rule 12(b)(6) motion, the relevant facts are as follows:

Verzicco worked for a company that provided its employees with a U.S. Health Care benefits plan. n2 Once an employee chooses to become a member of this plan, the employee selects out of a directory provided by U.S. Health Care a primary care physician. The primary care physician supervises, coordinates and provides initial care and basic medical services to its members. The primary care physician also refers the member for specialist care and maintains the continuity of patient care. Defendant Dr. Leonard Harman was Verzicco's primary care physician. Verzicco had been under Dr. Harman's care since November of 1977.

----------Footnotes----------

n2 It is undisputed that this plan constitutes a "employee benefit plan" as defined by ERISA, 29 U.S.C. @ 1002(1) and (3).

---------- End Footnotes ----------

On July 30, 1990, Verzicco visited Dr. Harman's office complaining of chest pain, mild shortness of breath, and [*5] numbness in her shoulders lasting about twenty minutes. Dr. Harman measured Verzicco's blood pressure, which was 150/88, and took an electrocardiogram which revealed an abnormality in t-waves. Dr. Harman ordered blood tests and the use of a Halter Monitor. After approximately one day, Dr. Harman discontinued use of the Halter Monitor because he was told by U.S. Health Care that it would not pay for the service of the Halter Monitor. Dr. Harman did not read the results of the day Verzicco wore the Halter Monitor.

On August 14, 1990, Verzicco began experiencing chest pains radiating across her shoulders, down her arm and up her neck. She went to the Emergency Room at Parkview where she was examined by the attending physicians, defendants Robert McAndrew, M.D. and Dr. Potman. Verzicco's blood pressure was 180/110 and the doctors ordered an electrocardiogram which showed evidence of anterior wall ischemia or infarction. Verzicco was given medication and was directed to return if her condition worsened. She was also instructed to contact Dr. Harman on Thursday, August 16, 1990.

The following day, while driving her car, Verzicco experienced extreme chest pain and passed out. She was [*6] rushed to Parkview where prolonged resuscitative efforts were performed. However, Verzicco remained unconscious with cardiac arrest and to this day has not regained consciousness. Verzicco suffered irreversible anoxic encephalopathy, which is expected to last for the rest of her life. Verzicco remains at the Fox Nursing Home and Rehabilitation Center where she has been in a persistent vegetative state.

In their complaint, plaintiffs assert, inter alia, claims for negligence, misrepresentation, and breach of contract

against U.S. Health Care with regard to the treatment rendered to Verzicco by her primary care physician. In its motion for reconsideration, U.S. Health Care continues to insist that all three claims are pre-empted by ERISA and should, therefore, be dismissed. We will address all three claims in seriatim. But first a word about ERISA pre-emption in general.

The pre-emption section of ERISA, 29 U.S.C. @ 1144(a) provides in relevant part that " . . . the provisions of this subchapter . . . shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan . . . " In determining that a state common [*7] law claim for tortious breach of contract was pre-empted by ERISA, the court in Pilot Life Insurance Company v. Dedeaux, 481 U.S. 41, 47 (1987) described the inclusive nature of the pre-emption clause:

In both Metropolitan Life (citation omitted) and Shaw v. Delta Airlines, Inc., (citation omitted), we noted the expansive sweep of the pre-emption clause. In both cases 'the phrase '[sic] relate to' was given its broadest common-sense meaning, such that a state law 'relates to a benefit plan' in the normal sense of the phrase, if it has a connection with or reference to such a plan.' (citations omitted) In particular we have emphasized that the pre-emption clause is not limited to 'state laws specifically designed to affect employee benefit plans.'

The court re-emphasized the broad scope of the pre-emptive effect of ERISA in Ingersoll-Rand Company v. McClendon, ___ U.S. ___, 111 S.Ct. 478, 482-83 (1990).

'The pre-emption clause is conspicuous for its breath [sic] (citation omitted).' Its 'deliberately expansive' language was designed to 'establish pension plan regulation as exclusively a federal concern (citation [*8] omitted).' The key to @ 514(a) is found in the words 'relate to.' Congress used those words in their broad sense rejecting more limited pre-emption language that would have made the

clause 'applicable only to state laws relating to the specific subjects covered by ERISA (citation omitted).' Moreover, to underscore its intent that @ 514(a) be expansively applied, Congress used equally broad language in defining the 'State law' that would be pre-empted. Such laws included 'all laws, decisions, rules, regulations or other state action having the effect of law.' 514(c)(1), 29 U.S.C. @ 1144(c)(1).

See also, The 1975 Salaried Retirement Plan for Eligible Employees of Crucible, Inc. v. Nobers, 968 F.2d 401 (3d Cir. 1992).

With those principles in mind, we now turn to plaintiffs' three state law claims to determine if indeed they are pre-empted by ERISA. We begin with plaintiffs' negligence claim. In that claim plaintiffs allege:

(i) All of the acts referred to above by all of the individual physicians and professional corporation physician, as well as, defendant Parkview, are imputed to defendant, U.S. Health Care, particularly [*9] since plaintiff, Verzicco, looked to U.S. Health Care for care and U.S. Health Care held out Dr. Leonard Harman, P.C. and Leonard Harman, M.D. as its employee. Verzicco justifiably relied upon the care and skill of Leonard Harman, M.D. based, in part, upon the assurances of defendant, U.S. Health Care, that Dr. Leonard Harman, P.C. and Leonard Harman, M.D., the primary care physician, were competent and qualified;

(ii) U.S. Health Care failed to exercise reasonable care in selecting, retaining and evaluating plaintiff's primary care physician and, as a result of its failure to use such reasonable care, the risk of harm to plaintiff, Verzicco, was increased resulting in the injuries and damages as set forth herein, thus, subjecting it to liability pursuant to 323 of the Restatement of Torts 2d;

(iii and iv) U.S. Health Care improperly instructed Leonard Harman, M. D. that it would not pay for the Halter Monitor causing him to discontinue its use after approximately one day and causing Dr. Harman to fail and refuse to read the results thereof, particularly when the continued use of the Halter Monitor was important for diagnosis and treatment based upon the complaints of Verzicco, and her history;

(v) Other acts of negligence of defendants, Dr. Leonard Harman, P.C. and Leonard Harman, M.D. pertaining to the medical treatment rendered to Verzicco.

Complaint at 41(c)1.

In our Memorandum Opinion of July 13, we found that all of the allegations in plaintiffs' negligence claim were predicated upon the negligence theory of "apparent" or "ostensible agency." Although an HMO is not usually liable for the negligence of the independent contractor physicians and health care providers that service the HMO members, an HMO may nevertheless be held liable if the health care provider is the "ostensible agent" of the HMO. Boyd v. Albert Einstein Medical Center, 377 Pa. Super. 609, 547 A.2d 1229 (1988). n3 At least with respect to paragraphs one, two and five of plaintiffs' negligence claim, plaintiffs are seeking to hold U.S. Health Care vicariously liable for the actions of Verzicco's primary physician acting ostensibly as an agent of U.S. Health Care. As such, the allegations contained in these paragraphs do not rely on obligations under U.S. Health Care's benefits plan, but on the principles of professional malpractice. [*11] See Kohn v. Delaware Valley HMO, Inc., C.A. No. 91-2745 (E.D. Pa. December 19, 1991) (Hutton, J); Independence HMO, Inc. v. Smith, 733 F.Supp. 983, 987-989 (E.D. Pa. 1990). Our Court of Appeals recently opined, in Painters of Philadelphia District Council No. 21 Welfare Fund v. Price Waterhouse, 879 F.2d 1146 (3d Cir. 1991), "that ERISA does not generally

pre-empt state professional malpractice actions." Id. at 1153, n. 7. In rejecting the argument that an implied cause of action existed under ERISA for medical malpractice claims, the Court of Appeals stated:

. . . state law has traditionally prescribed the standards of professional liability and, in the absence of clear indicia in the act or legislative history, we are reluctant to ascribe to Congress an intention to intrude in this area. Far from there being clear indicia of an intent to create an implied professional malpractice cause of action under ERISA, there is not a scintilla of evidence that Congress had this in its mind . . .

Id. at 1152-53. We, therefore, find that paragraphs one, two [*12] and five of plaintiffs' negligence claim are not pre-empted by ERISA.

----------Footnotes----------

n3 In Boyd, the Pennsylvania Court found that "the two factors relevant to a finding of ostensible agency are: (1) whether the patient looks to the institution, rather than the individual physician for care, and (2) whether the HMO "holds out" the physician as its employee." 547 A.2d at 1233. In paragraph one of their negligence count, plaintiffs specifically allege that "Verzicco looked to U.S. Health Care for care and U.S. Health Care held out Dr. Leonard Harman, P.C. and Leonard Harman, M.D. as its employee."

---------- End Footnotes ----------

The allegations in paragraphs three and four of plaintiffs' negligence count, however, present a different story. In those paragraphs plaintiffs allege that U.S. Health Care improperly instructed Dr. Harman that it would not pay for the Halter Monitor. Plaintiffs are not seeking to hold U.S. Health Care liable on a vicarious basis for acts of negligence allegedly committed by Dr. Harman while [13*] acting ostensibly as an agent of U.S. Health Care.

Rather, plaintiffs seek to hold U.S. Health Care directly liable, for refusing to pay for the Halter Monitor under its benefits plan. Such a claim for failure to provide funding clearly has a "connection with or reference to" a benefit plan. See Corcoran v. United Healthcare, Inc., No. 91-3322, 1992 U.S. App. Lexis 14621 (5th Cir. June 26, 1992). (Plaintiffs' claim that U.S. Health Care was negligent in failing to pre-certify payment for certain medical services held pre-empted by ERISA); Kohn, supra (plaintiffs' claim that the defendant HMO failed to provide finding to the plaintiff decedent's family for treatment that their own therapists prescribed for plaintiff decedent held pre-empted by ERISA). We, therefore, find that paragraphs three and four of plaintiffs' negligence count are pre-empted by ERISA.

Having found that all of plaintiffs' negligence claims with the exception of paragraphs three and four are not pre-empted by ERISA, we turn to plaintiffs' claims for misrepresentation and breach of contract against U.S. Health Care. In those clams [sic], plaintiffs allege:

(i) U.S. Health [14*] Care intentionally misrepresented that each and every primary care physician, including Leonard Harman, M.D. and Dr. Leonard Harman, P.C., satisfied criteria for participation as a qualified physician after passing vigorous screening criteria established by U.S. Health Care and the primary care physician with whom Verzicco enrolled under the terms of the contract with U.S. Health Care would perform all necessary medical care and treatment and any diagnostic tests which were necessary, including referring Verzicco to a coronary care unit or hospital, if necessary;

(ii) Verzicco relied upon the statements of U.S. Health Care which were intentionally false and misleading, and, as a result of her reliance, she sustained the injuries described herein;

(iii) The misrepresentations and fraudulent utterances were intended by U.S. Health Care to cause Verzicco to act by subscribing to U.S. Health Care as an HMO and Verzicco justifiably relied upon the misrepresentations with resultant damages as the proximate result thereof;

(iv) The misrepresentations, even if innocent by U.S. Health Care, relates to matters material to the choice and continued use of a health care provider by Verzicco [*15] since it was in such a character that if the misrepresentations had not been made, Verzicco would not have joined U.S. Health Care, or would not have chosen and continued to use Leonard Harman, M.D. as her primary care physician;

(i) U.S. Health Care through contracts and other documents that are within the possession of U.S. Health Care promised that the primary care physicians, including Leonard Harman, M.D., had to undergo vigorous screening and meet certain criteria to be qualified as a primary care physician for U.S. Health Care, and promised that Leonard Harman, M.D. did undergo this screening, met the criteria and was qualified as a primary care physician and that the patient would be referred by Leonard Harman, M.D. to appropriate specialists or hospitals as required for necessary medical treatment and Verzicco enrolled herself and her family with U.S. Health Care for all of her medical care and executed a contract with U.S. Health Care for U.S. Health Care to provide said medical care;

(ii) U.S. Health Care breached the provisions of the contract which required it to provide Verzicco with a qualified primary care physician to provide reasonably competent medical care, including [*16] appropriate referrals;

(iii) As a result of the breach, Verzicco suffered the injuries described herein.

Complaint at 41(c)2,3.

In our Memorandum Opinion of July 13, we lumped plaintiffs' misrepresentation and breach of contract claims with plaintiffs' negligence claim and found that all three claims attempted to hold U.S. Health Care liable in a vicarious capacity for the actions of Verzicco's primary care physician. Upon further reflection, however, we find that each of plaintiffs' three claims are separate and distinct from each other and must be considered individually.

As noted above, the nature of plaintiffs' misrepresentation claim is that U.S. Health Care misrepresented that the primary care physician with whom Verzicco enrolled under the terms of the contract with U.S. Health Care would perform all necessary medical care and treatment. This claim obviously has a connection with or reference to a benefit plan as it is based on representations over the extent of and nature of the care provided under the benefit plan. Plaintiffs' claim for misrepresentation is, therefore, pre-empted by ERISA. See Berger v. Edgewater Steel Co., 911 F.2d 922, 923 (3d Cir. 1990). [*17] (ERISA pre-empted state law claim for misrepresentation); Bernatowicz v. Colgate-Palmolive Co., 785 F.Supp. 488, 493 (D.N.J. 1992).

Plaintiffs' breach of contract claim is likewise pre-empted by ERISA. In that claim, plaintiffs allege that U.S. Health Care breached the provisions of the contract when it failed to provide Verzicco with a qualified primary care physician. Again, this claim obviously has a connection with a benefit plan, as it is based on an alleged contractual obligation under the benefit plan to provide for a qualified primary care physician. See Pane v. R.C.A. Corp., 868 F.2d 631, 635 (3d Cir. 1989); Kohn, supra.

The fact that ERISA may not offer a remedy for plaintiffs' pre-empted claims does not alter our conclusion. Although our Court of Appeals has not addressed the issue, the Courts of Appeals for the Fifth and Seventh Circuits have both held that a claim is still pre-empted under ERISA even if the plaintiff is left without a remedy. See Corcoran, supra; Lister v. Stark, 890 F.2d 941, 946 (7th Cir. 1989), cert. denied, 111 S.Ct. 579 (1990). [*18] See also Weir v. Northwestern National Life Insurance Company, 1992 U.S. Dist. LEXIS 9653 (E.D. Pa. July 2, 1992).

In sum, plaintiffs' claims against U.S. Health Care for misrepresentation, breach of contract and negligence (paragraphs three and four only) will be dismissed as pre-empted by ERISA. The remainder of the action, including the remainder of plaintiffs' negligence claim against defendant U.S. Health Care will be remanded to the Court of Common Pleas of Philadelphia County.

ORDER – October 1, 1992, Entered

The motion of the defendant U.S. Health Care Systems of Pennsylvania, Inc. for reconsideration is GRANTED in part and DENIED in part.

The motion of the defendant U.S. Health Care Systems of Pennsylvania, Inc. for certification is DENIED.

The Order of this Court dated July 13, 1992 is VACATED.

In its stead, it is ORDERED that:

The motion of the defendant United States Health Care Systems of Pennsylvania, Inc. to dismiss the complaint is GRANTED in part and DENIED in part.

The motion of the plaintiffs to remand is GRANTED in part and DENIED in part.

Plaintiffs' claims for misrepresentation, breach of contract and negligence (paragraphs [*19] three and four

only) against U.S. Health Care are DISMISSED as pre-empted by ERISA.

The remainder of the action, including the remainder of plaintiffs' negligence claim against defendant U.S. Health Care is REMANDED to the Court of Common Pleas of Philadelphia County.

Defendant U.S. Health Care is not responsible for plaintiffs' attorney's fees and costs as originally stated in our July 13 Order.

The Clerk is DIRECTED to mark this case closed.

IT IS SO ORDERED.

CHARLES R. WEINER